Walgreens
335 Prairie Ave, Providence, RI 02905
Phone: 1-401-781-4390
Fax: 1-401-781-4645

Hepatitis C Prior Authorization Form
Customer Service: 1-401-459-6020
Fax: 1-866-423-0945

Instructions:
- The form is to be used by participating physicians and providers to obtain coverage for drugs to treat hepatitis C.
- Please complete both pages and **fax this prior authorization form along with all applicable documentation required directly to Neighborhood Health Plan of Rhode Island at 1-866-423-0945 to prevent any delays in review**.
- **Please fax the prescription to the local Walgreens Pharmacy located at 335 Prairie Ave in Providence, RI at 1-401-781-4645**.

Please complete the following information: Date of Request: ___/_____/_____

Do you need this request decisioned within 24 hours? (72 hours is our normal turn-around-time)

PATIENT INFORMATION (complete all requested information)

Patient Name:____________________ DOB:__________ Male ❑ Female ❑
Address: ____________________ City:__________ State:________ Zip Code: __________
Phone #:______________ E-mail Address: ______________ Drug Allergies: ______________
Insurance Provider (**Please include copy of front and back of card**): ______________ ID#: __________
Policy/Group #:__________ Phone #: __________ Relationship to Patient: Self ❑ Other: ______________

CLINICAL ASSESSMENT (complete all requested information)

Hepatitis C genotype:	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑Other:____
Most recent viral load: **Testing date must be within 90 days of this PA request**	______________ IU/mL Test date: __________
Hepatic fibrosis stage:	❑ stage 0 ❑ stage 1 ❑ stage 2 ❑ stage 3 ❑ stage 4
Test used to determine disease stage (check all that apply)**:** **Documentation must be submitted with PA request**	❑ AST to Platelet Ratio Index (APRI) ❑ Fibroscan score ❑ Fibrotest score ❑ Imaging study consistent with cirrhosis ❑ Liver biopsy indicating METAVIR score ❑ Other, please specify: ______________

Is cirrhosis present? ❑ Yes ❑ No
If yes, please indicate if patient has compensated or decompensated cirrhosis?: ❑ compensated ❑ decompensated
If decompensated cirrhosis, then please answer questions below:
(a) Does patient have moderate or severe hepatic impairment class B or C? ❑ Yes ❑ No
(b) Is patient under the care of a specialist with experience in that condition – ideally in a liver transplant center? ❑ Yes ❑ No

Treatment status:	❑ treatment naïve ❑ retreatment ❑ currently on therapy (start date: ______________)
Provide previous Hepatitis C drug therapy (if applicable)**:**	○ Drug(s):______________ Dose: ________ Date(s): ________Side effect/Inadequate response ○ Drug(s):______________ Dose: ________ Date(s): ________Side effect/Inadequate response ○ Drug(s):______________ Dose: ________ Date(s): ________Side effect/Inadequate response

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PRESCRIPTION INFORMATION (complete all requested information)

	Medication Name	Directions	Quantity	Refills
❑	Mavyret (glecaprevir/pibrentasvir)			
❑	Vosevi (sofosbuvir/velpatasvir/voxilaprevir)			
❑	Other (specify name & strength): ______________________			

HEPATITIS C TREATMENT START DATE

If criteria are met, Neighborhood will authorize the requested drug(s) for the duration of therapy. Date ranges for authorizations are based on the patient's therapy start date.

- Provide the date patient is to start therapy with requested drugs: ____________________

PRESCRIBER INFORMATION (complete all requested information)

Prescriber's Name: ______________________ Specialty: ______________________
Address:______________________ Office Contact: ______________________
City:______________ State:______ Zip Code: ______Phone #:______________Fax: ________
State License #:__________ NPI#:______________ Medicaid UPIN #: ______________

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required:______________________________________ **Date**: __________

PRESCRIBER PREFERRED PROVIDER STATUS with the State of RI EOHHS

Prescribers of hepatitis C drugs are required to be enrolled as a Preferred Provider for hepatitis C medications with the State of Rhode Island Executive Office of Health & Human Services (EOHHS).

- Does provider have Preferred Provider Status (PPS) with Rhode Island EOHHS: ❑ Yes ❑ No

State of RI EOHHS preferred provider status applications can be accessed at:
http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Pharmacy/PharmacyPriorAuthorizationProgram.aspx

Physician Assistants and Nurse Practitioners employed and co-located with a Physician on the Preferred Provider List may request Preferred Provider status.